REPRIEVE

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By Post and Email: aprzybyl@anipharmaceuticals.com

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Dear Mr Przybyl

Urgent: Use of Reglan in force-feeding detainees at Guantánamo Bay

I am the Strategic Director of Reprieve, a legal action charity that helps those denied justice in the 'war on terror' – including 17 men currently detained at Guantánamo Bay. You will undoubtedly have seen press coverage of the widespread hunger strikes at the prison. Between 130 and 140 of the 166 remaining detainees are now striking to protest their indefinite detention and the military's harsh treatment of them. At least 38 are being force-fed, including several Reprieve clients.[1]

I am writing to you because it appears that one of your company's products – Reglan[2] – is used during the force-feeding of hunger-strikers at Guantánamo. It is highly likely that prisoners are being medicated with Reglan without their informed consent. There is also a grave risk it is being administered for extended periods that may cause severe neurological side-effects.

My hope is that you will assist us in stopping this misuse of your drug.

Use of Reglan in force-feeding

You may have seen the Department of Defense's recently published "Standard Operating Procedure for Medical Management of Detainees on Hunger Strike", the rulebook for force-feeding at Guantánamo.[3] A copy is enclosed for your convenience. The SOP instructs medical staff force-feeding Guantánamo prisoners to use "Reglan 10 mg PO/enteral feeding tube Q 3 hr X 3 doses" where a detainee is nauseated or bloated after a tube is inserted for force-feeding.

The force-feeding staff are also advised "to enhance gastric motility" in strikers by administering "Metoclopramide (Reglan) 10 mg via enteral feeding tube (place in feeding bag before nutritional supplement)". To be clear, 'intermittent feeding' is the US military euphemism for regular force-feeding of prisoners who have been checked out of hospital. This includes the majority of people being force-fed in Guantánamo. Critically, the SOP says nothing about side-effects or informed consent.

Your company is the only FDA-approved manufacturer of Reglan 10mg tablets, so we must conclude that your product is being used for these purposes at Guantánamo.[4] And while I assume ANI had no advance knowledge of this unfortunate fact, this does mean your drug has been conscripted in a practice that the vast majority of medical opinion considers unethical.

[1] http://www.miamiherald.com/static/media/projects/gitmo_chart/

[2] http://www.anipharmaceuticals.com/products_view.php?i=69;
http://www.anipharmaceuticals.com/aboutus_newsmedia_view.php?i=6

[3] http://www.aljazeera.com/humanrights/2013/05/201358152317954140.html (page 16)

[4] http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.DrugDetails

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Professional condemnation of force-feeding and prisoner descriptions of the practice

The medical profession overwhelmingly condemns force-feeding hunger strikers as unjustifiable, unethical and counter-productive. The World Medical Association states unequivocally that force-feeding "contrary to an informed and voluntary refusal" is "unjustifiable", "never ethically acceptable" and that even if intended to benefit a person, is "a form of inhuman and degrading treatment".[5]

The American Medical Association has also repeatedly opposed force-feeding and urged the US government to abandon the technique. On April 25 the position was reinforced by Dr. Jeremy Lazarus, president of the AMA, in a letter to Defense Secretary Chuck Hagel.[6]

One understands this professional outcry when one hears the harrowing stories of prisoners put through the Guantánamo force-feeding regime. During force-feeding, my clients are strapped in chairs and their heads held immobile for as long as two hours.[7] One of my clients, Nabil Hadjarab, said the chair "reminds me of an execution chair. Your legs and arms are tied with belts. Your shoulders are tied with belts. If you refuse to let them put the tube in, they force your head back."

A tube is then passed through the nose and into the stomach. My client Samir Moqbel described this in a New York Times piece: "I will never forget the first time they passed the feeding tube up my nose. I can't describe how painful it is to be force-fed this way. As it was thrust in, it made me feel like throwing up. I wanted to vomit, but I couldn't. There was agony in my chest, throat and stomach. I had never experienced such pain before. I would not wish this cruel punishment upon anyone."[8]

I am confident ANI Pharmaceuticals, as a responsible brand, does not want to be associated with this brutal practice. This is all the more worrying when one realizes that the Guantánamo authorities are likely exposing hunger-strikers to an unacceptable risk of Reglan's side-effects.

Possible side-effects of Reglan

As you will be well aware, prolonged use of Reglan can cause tardive dyskinesia, a neurological muscular disorder.[9] Symptoms of tardive dyskinesia can develop and persist long after medication has been discontinued. ANI's guidance on use of the drug is clear: Reglan is not meant to be taken for longer than 12 weeks because of this risk.[10] For the same reasons Reglan was included in the FDA's REMS ('Risk Evaluation and Mitigation Strategies') program for drugs.[11]

The hunger strike at Guantánamo began in early February 2013. Force-feeding of prisoners had begun by at least March 4[12] – three months ago – and therefore has been going on for over the 12 weeks' maximum recommended use of Reglan. Remember, the military SOP says nothing about informing prisoners of this risk. At this moment, Reglan may be causing prisoners an acute risk of tardive dyskinesia without their even knowing they are taking it.

[5] http://www.wma.net/en/30publications/10policies/h31/index.html

[6] http://www.ama-assn.org/ama/pub/category/16086.html; https://www.documentcloud.org/documents/694196-hunger-strikers-letter-04-25-13.html

[7] http://www.globalresearch.ca/guantanamo-hunger-strike-force-feedings-continue/5333705

[8] http://www.nytimes.com/2013/04/15/opinion/hunger-striking-at-guantanamo-bay.html?_r=0

[9] http://www.tardivedyskinesia.com/

[10] http://www.anipharmaceuticals.com/dynamic/file_guide_69.pdf

[11] http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111350.htm

[12] http://www.miamiherald.com/2013/03/04/3266793/lawyers-claim-guantanamo-prison.html

I am also concerned that the listed side effects of Reglan include depression, thoughts about suicide and suicide.[13] Given that most prisoners at Guantánamo have been held without charge for over 11 years, and have been driven to hunger strike because they see no hope of release, the potential risks of depressive medications are serious. Several of our clients have recently reported suicidal thoughts or suicide attempts among hunger-striking prisoners.

Again, I am confident you would never wish to hear your product had led to long-term damage in detainees who were deprived of their right to refuse treatment.

Action required:

I am sure you will agree that the use of Reglan in the force-feeding of Guantánamo detainees is incompatible with your company's aims. It places one of your products, intended to promote health, at the centre of a notorious and ongoing human rights violation, and will cause irreparable damage to your corporate reputation. The use of Reglan at Guantánamo also risks long-term medical mental and physical damage to patients who have been given no chance to assess the risks associated with the drug. The forcible administration of Reglan places you in potential breach of your duty as a manufacturer to warn of these adverse side effects, since any warning pamphlet is obviously made otiose in these circumstances.

There are a number of actions your company could take to ensure that Reglan is not used in force-feeding at Guantánamo. As a pharmaceutical company producing specialty drugs, you will be familiar with the different models used to control the distribution of products carrying particular risks. Indeed, a number of your distributors (including Cardinal, McKesson and AmerisourceBergen) offer restricted solutions which you could use to prevent abuse of your products. You should urgently develop a system for controlling the distribution of this product, so that you extricate your company from this brutal practice.

You will undoubtedly be aware of the UN Guiding Principles on Business and Human Rights, which call upon all businesses to avoid infringing the human rights of others, and to address adverse human rights impacts with which they are involved.

I would be happy to discuss the steps that you could take to control the distribution of Reglan and to prevent your product from being used in further force-feeding at Guantánamo Bay. Reprieve has been working with pharmaceutical manufacturers for many years in relation to the supply of drugs for use in lethal injection, and we have a great deal of expertise.

I must emphasise, however that this is extremely urgent. I am available to discuss at any time, and would appreciate a response at your earliest convenience, and in any event within seven days (i.e. by 11 June 2013).

Yours sincerely,

Cori Crider
Enclosures (1)

[13] http://www.accessdata.fda.gov/drugsatfda_docs/label/2011/017854s058lbl.pdf; http://www.fda.gov/downloads/Drugs/DrugSafety/UCM235574.pdf

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JOINT TASK FORCE GUANTANAMO BAY, CUBA **JOINT MEDICAL GROUP** **Title: MEDICAL MANAGEMENT OF DETAINEES ON HUNGER STRIKE**	**SOP NO: JTF-JMG #001** **TAC Memo #01** **TAC Memo #02**
SCOPE: JOINT TASK FORCE - GTMO- JOINT MEDICAL GROUP	

REFERENCES:

ENCLOSURES:

(1) General Algorithm for Hunger a Strike
(2) Refusal to Accept Food or Water/Fluids as Medical Treatment
(3) Hunger Striker Medical Evaluation Sheet
(4) Hunger Striker Medical Flow Sheet
(5) Approval Authority for Initiation of Involuntary Enteral Feeding
(6) Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike
(7) Chair Restraint System Clinical Protocol for the Intermittent Enteral Feeding of Detainees on Hunger Strike
(8) Medical Equations, Calculations and Definitions
(9) Management of Common Electrolyte Deficiencies
(10) Medical Management of Enterally Fed Detainees Who Terminate Their Hunger Strike
(11) Procedures for Setting up an Enteral Feed (TAC Memo #1)
(12) Strategy for Detainee Biting Feed Tube (TAC Memo #2)

2. BACKGROUND

Hunger strikes can be expected in any detained population. A prolonged period of time without adequate food and water will have adverse health effects. Identification and early medical management of detainees on hunger strike may prevent adverse health effects and death.

Just as battlefield tactics must change throughout the course of a conflict, the medical response to GTMO detainees who hunger strike has evolved with time. From a peak of over 100 detainees who were on a hunger strike, currently there are less than a dozen. A mass hunger strike was successfully dealt with by utilizing procedures adopted from the Federal Bureau of Prisons and the approach delineated in this SOP. However, the composition of the detainee population, camp infrastructure, and policies has all undergone significant change since the initial version of this SOP. Several of the current group of detainees has been hunger striking since 2005. This group of detainees has proven their determination and their chronic malnourishment has left them physically frail. Given these conditions, options for intervention are more limited. Maintaining

health and nutrition under these circumstances is challenging, and this SOP has been revised to reflect current tactics and practice. Much of the original instruction has been retained in the form of enclosures. In the event of a mass hunger strike, these enclosures can be utilized as they have proven efficacy under mass hunger strike conditions.

In general, utilizing the clinical judgment of the Senior Medical Officer (SMO) and the Medical Staff, vice rote adherence to an algorithmic approach, has proven useful. Several of the detainees on hunger strike have been moved to Camp VI (a communal environment) after achieving a target weight goal (at least 70% of Ideal Body Weight). Although they continue to receive periodic enteral feeding support at Camp VI, they are also consuming food orally, and the communal support of the other detainees encourages them to eat. The incentive to earn transfer to communal living is a recent development and should continue to be encouraged.

II. POLICY

A. The DoD and Joint Task Force Guantanamo (JTF GTMO) policy is to protect, preserve, and promote life. This includes preventing any serious adverse health effects and death from hunger strikes. The Joint Medical Group (JMG) staff is responsible for providing health care monitoring and medical assistance as clinically indicated for detainees on a hunger strike. The Commander, JMG will ensure that the medical staff adheres to the procedures outlined in this document. The JMG staff will do everything within its means to monitor, preserve, and protect the health and welfare of hunger striking detainees. When evaluating and treating a detainee on hunger strike, JMG medical personnel will make reasonable efforts to obtain voluntary consent for medical treatment. When consent cannot be obtained, medical procedures that are indicated to preserve health and life shall be implemented without consent from the detainee.

B. In the event a detainee refrains from eating or drinking to the point where it is determined by medical assessment that continued fasting will result in a threat to life or seriously jeopardize health, and involuntary feeding is required, no direct action will be taken without the knowledge and written approval of the JTF-GTMO Commander. If the JTF-GTMO Commander makes the decision to authorize involuntary feeding of a detainee, he/she will immediately inform the Commander, United States Southern Command (USSOUTHCOM) of his/her decision. In turn, the Commander USSOUTHCOM, will notify appropriate Joint Staff and Department of Defense offices of the necessity of initiating involuntary feeding of a detainee. This approval authority does not preclude the Medical Officer from performing any emergent actions deemed medically necessary to preserve life and health.

C. Definitions.

1. **Hunger striker**. A hunger striker is a detainee who communicates either directly or indirectly (i.e. repeated meal refusals) his intent to undergo a hunger strike or fast as a form of protest or to demand attention. A detainee may be designated a hunger striker after missing nine consecutive meals or weight loss to a level less than 85% Ideal Body Weight (IBW). The designation of a detainee as a hunger striker is based on intent, purpose, and behavior and will be

determined by the Commander, JMG in conjunction with input from the JMG medical staff and the Commander, Joint Detention Group (JDG). In general, lack of sufficient daily caloric intake is a more useful measure to designate a hunger striker than the number of consecutive meals missed.

2. **Meal**. A meal is the combined or individual consumption of fluids and/or solid food required to maintain daily metabolic requirements. These requirements vary by individual. For the purpose of this document, any consumption of calories at or around 500 Kcal is considered a regular meal. Examples would include two, eight fluid ounce containers of Ensure® or similar nutritional supplements or the meal from a regular diet.

3. Enteral feeder. A detainee on a hunger strike, who has been approved for involuntary enteral feeding by the Commander, Joint Task Force Guantanamo (JTF GTMO)

4. Chronic enteral feeder. A detainee who has chosen to hunger strike for a prolonged period of time (generally >30 days) and has been receiving regular enteral feedings. These detainees are chronically underweight, but have generally achieved a medically stable status.

5. Enteral feeder on hold. An enteral feeder who is not receiving enteral feeding via a Nasogatric tube (NGT). The Senior Medical Officer (SMO) will consider a change to this status when the detainee has not received an enteral feed via NGT for greater than 7 days, and is consuming an adequate quantity of oral calories. An enteral feeder on hold does not yet qualify for removal from the Hunger Strike List.

6. Hunger Striker on medical observation. A detainee on a hunger strike who has not yet been approved for involuntary enteral feeding by the Commander, JTF GTMO.

III. PROCEDURES

A. Effective management of individuals or groups who refuse to eat or drink requires a close partnership between the JMG medical staff and the Joint Detention Group (JDG) security force. Enclosure (1), *General Algorithm for a Hunger Strike*, provides a simplified outline for the medical management of detainees on hunger strike. JDG Procedure #38, *Hunger Striker Protocol*, details the JDG role in this process.

B. Security forces under the JDG will monitor each detainee's daily intake of meals and water. Entries will be made in the Detainee Information Management System (DIMS) to document when a meal is missed.

C. The JDG will notify the JMG medical staff of any detainee who meets the definition of a hunger striker as outlined above; and will maintain a current missed meals list on that detainee. This list will be communicated via e-mail, phone or memorandum to the Senior Medical Officer (SMO) and the Senior Nurse Executive (SNE) or their representatives each day. Included in this list will be a running total of consecutive missed meals by each detainee who is on a hunger

strike. In addition, JDG should include in this list those detainees who may not be consuming adequate nutrition and fluids, but who have not met criteria for a hunger strike.

D. Once notified, medical personnel will evaluate each detainee considered to be on a hunger strike. Part of this evaluation will be to determine the intent and purpose of the meal/drink refusal. The JMG-GTMO Commander , with input from the JMG medical staff and the JDG Commander, will determine whether the actions of a detainee meet the criteria for a hunger strike as outlined above. The SMO or his/her representative will forward a daily list of those detainees on hunger strike to key leadership in the JTF to include the JTF-GTMO Commander, the JTF-GTMO Deputy Commander, the Chief of Staff, the JDG Commander, the JMG commander, the JDG Operations Officer (S3), the guard force commanders and the SNE. The JMG Situation Report (SITREP) will reflect the total number of detainees on hunger strike.

E. A JMG medical provider will counsel the detainee who is on a hunger strike as to the medical hazards of a prolonged period without food and/or water. Enclosure (2), *Refusal to Accept Food or Water/Fluids as Medical Treatment,* will be verbally translated at the initial assessment. The medical staff shall explain the medical risks faced by the detainee and make a reasonable effort to convince the detainee to resume eating food and drinking water. Enclosure (2) will be signed by the medical provider, witness and translator and placed in the detainee's outpatient medical record.

F. If during the course of a hunger strike, involuntary feeding is required, the Senior Medical Officer, via the JMG-GTMO Commander, will make specific recommendations to the JTF-GTMO Commander as to the timing and requirement for such involuntary feeding. The JTF-GTMO Commander will decide whether to order the involuntary feeding of a detainee and his/her authorization will be documented via Secure Internet Protocol Router Network (SIPRNET) email. If the JTF-GTMO Commander authorizes involuntary feeding of a detainee, he/she will immediately inform the Commander, USSOUTHCOM of his/her decision. In turn, the Commander USSOUTHCOM will notify appropriate Joint Staff and Department of Defense offices of the necessity for initiating involuntary feeding of a detainee.

IV. MEDICAL EVALUATION AND MANAGEMENT

A. The medical staff will monitor the health of any detainee who is on a hunger strike. Upon notification that a detainee is on a hunger strike, medical personnel will document the following:

1. Using Enclosure (3), *Hunger Striker Medical Evaluation Sheet,* a medical provider will perform a complete medical record review, an intake (food/fluids) history, and a general physical examination to include vital signs, weight, % Ideal Body Weight (IBW), and body mass index (BMI). If clinically indicated, appropriate laboratory tests will be obtained to assess the detainee's metabolic status. If laboratory tests are indicated, the following are recommended: Urinalysis, serum basic metabolic profile, liver function tests (LFTs), Magnesium (Mg), phosphate (PO4) and calcium (Ca). If clinically indicated, an EKG can be obtained at this time.

Once completed, Enclosure (3) will be signed by the medical provider and placed in the detainee's outpatient medical record.

2. Behavioral Healthcare Service (BHS) will perform an assessment of the mental and psychological status of the detainee, which will be documented in the outpatient medical record on a Standard Form 600. BHS will continue to regularly evaluate detainees who continue on a hunger strike.

3. After the initial evaluation, the detainee will be evaluated on a daily basis using Enclosure (4), *Hunger Striker Medical Flow Sheet*. This form is maintained electronically on the network share drive. When the detainee is removed from the hunger strike list, a copy of the flow sheet will be filed in the detainee's outpatient medical record.

B. When a JMG Medical Officer determines that the detainee's life or health might be threatened if treatment is not initiated, the Senior Medical Officer will give consideration to involuntary medical treatment of the detainee. Involuntary medical treatment should be considered if any of the following clinical criteria are met:

1. There is evidence of deleterious health effects reflective of end organ involvement or damage to include, but not limited to, seizures, syncope or pre-syncope, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are significantly hampered.

2. There is a pre-existing co-morbidity that might readily predispose to end organ damage (e.g. hypertension, coronary artery disease or any significant heart condition, renal insufficiency or failure, or endocrinopathy).

3. There is a prolonged period of hunger strike (more than 21 days).

4. The detainee is at a weight less than 85% of the calculated Ideal Body Weight (IBW).

5. The detainee has experienced significant weight loss (greater than 15%) from previously recorded or in-processing weight. These criteria are suggested guidelines, and are not intended to replace the clinical judgment of the SMO and medical staff

C. Prior to medical treatment being administered, medical staff will make reasonable efforts to convince the detainee to voluntarily resume eating or accept treatment. The JMG staff will explain medical risks the detainee faces if he does not accept treatment.

1. Involuntary medical treatment may include, but is not limited to, intravenous fluids, blood draws, weights, and/or administration of nutritional formulas or electrolyte solutions via an enteral feeding tube. When, after reasonable efforts, or in an emergency preventing such efforts, a medical necessity for treatment of a life or serious health-threatening situation exists, the Senior Medical Officer may recommend that treatment be administered without the consent of the detainee.

2. No direct action will be taken to involuntarily feed a detainee without the written approval of the JTF-GTMO Commander as set out above, unless a medical emergency exists. Medical staff shall document all of their counseling efforts and treatments in the detainee's medical record.

3. If involuntary enteral feeding is clinically indicated and authorized, Enclosure (5), *Approval Authority for Initiation of Involuntary Enteral Feeding,* should be completed by the Senior Medical Officer and placed in the detainee's inpatient medical record.

D. If the Senior Medical Officer determines that the medical condition of a detainee on hunger strike dictates medical intervention to preserve health or life, the detainee will be admitted to the Detention Hospital (DH) if medically indicated, or transferred to a designated feeding block for possible involuntary enteral feeding.

1. Clinical protocols for enteral feeding using a graduated continuous enteral feed infusion are found in Enclosure (6), *Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike*. If the Senior Medical Officer deems it medically safe (low risk of re-feeding syndrome) based on the duration of the detainee's fast or hunger strike, enteral feeding may be initiated with graduated intermittent feeds as opposed to a continuous infusion.

2. Clinical protocols for enteral feeding using an intermittent infusion are also found in Enclosures (6). Enclosure (7) describes instructions for the use of the Feeding Chair Restraint system for intermittent enteral feedings and Enclosure (8), *Medical Equations, Calculations and Definitions* may be used to calculate caloric goals/needs.

3. Enclosure (9), *Management of Common Electrolyte Deficiencies*, outlines means of correcting common electrolyte deficiencies seen in individuals on a hunger strike or prolonged fast. If a hunger-striking detainee needs electrolyte correction, long-term hydration or continuous enteral feedings he must be admitted to the DH.

V. REMOVING A DETAINEE FROM ENTERAL FEEDING

A. The following guidance will be used to remove a detainee from enteral feeding:

1. A variety of methods may be utilized to transition an enteral feeder from enteral formula to a regular diet. The Senior Medical Officer will determine the method utilized for transition to regular food. In general, a 3 to 5 day period should be sufficient to transition the enteral feeder to a regular diet. If the detainee has been intermittently consuming regular food while on a hunger strike, this transition can be achieved sooner.

2. One approach is to provide 3 cans of Ensure TID for 3 days, and provide dietary recommendation to initially consume soft or bland foods

3. Enteral formula should not be provided beyond the 3 to 5 day period unless medically necessary. This will avoid the potential for a detainee to claim a special status or continue to claim hunger strike status.

4. A hunger striker who has not received enteral feeding may be removed from the Hunger Strike List if he eats an average of 1500 calories or greater per day for 3 days or 3 consecutive meals.

5. An enteral feeder may be removed from the Hunger Strike List if he eats an average of 1500 calories or greater per day for 7 days or 9 consecutive meals.

6. The Senior Medical Officer may also remove a detainee from the Hunger Strike List based on medical assessment that the caloric intake is sufficient for survival and it is suspected that the detainee's intent is not to hunger strike.

7. Enclosure (10), *Medical Management of Enterally Fed Detainees Who Terminate Their Hunger Strike*, outlines a proposed pathway to assist and monitor detainees in their transition from enteral feeding to a regular diet, and is included for historical interest.

8. Once removed from the hunger strike list, the SMO or his/her designated representative will notify JDG Operations (S3) personnel via phone call, SIPRNET e-mail, or in writing when a detainee is removed from the hunger strike list.

GENERAL ALGORITHM FOR A HUNGER STRIKE

Detainee misses nine consecutive meals or meets other criteria of a possible hunger striker.

⇩

Medical officer performs a physical examination and BHS performs psychological evaluation and designates detainee as a potential hunger striker. The detainee is counseled on the medical dangers of a hunger strike. Enclosures (2) and (3) are completed and placed in detainee's medical record.

⇩

The hunger striker is monitored daily to include weight, hydration status, and general health (documented using Enclosure (4). Detainee may be resuscitated with intravenous hydration as clinically indicated. If the detainee has sufficient caloric intake for 3 days and is cleared by a Medical Officer, he is removed from hunger strike list.

⇩

If detainee continues to hunger strike and clinical criteria for the initiation of enteral feeding are met per Paragraph IV.B. of SOP 001, the detainee may be admitted to the Detention Hospital or designated feeding block if medically stable. Authorization is obtained via chain-of-command from JTF-GTMO Commander to begin enteral feeding.

⇩

If clinically indicated, continuous or intermittent infusion of enteral feeding is initiated per Enclosure (6). .

⇩

. Intermittent enteral feeds are performed under physician and nurse supervision. If the medical condition of the detainee requires closer observation, he will be kept in the Detention Hospital.

⇩

On feeding block (or Detention Hospital), medical staff closely monitors weights, laboratory tests, and general health of enterally fed detainees and evaluates and treats any side effects or complications of hunger striking. See Enclosure (6).

⇩

Involuntary enteral feeding shall be discontinued for detainees who have attained a calculated Ideal Body Weight (IBW) of 100% for fourteen (14) or more consecutive days of enteral feeding, provided that an attending physician deems this medically appropriate.

⇩

When detainee begins to eat voluntarily, or after he is removed from enteral feeding based on 14 consecutive days of 100% IBW, he is observed closely for re-feeding syndrome or food intolerance. Begin oral feedings with a bland diet and advance as tolerated to a regular diet.

⇩

After having sufficient caloric intake for 3 days, the detainee is removed from the hunger strike list and transferred to an observation block for further monitoring (approximately nine additional meals).

⇩

Detainee is returned to normal detainee population. A physical evaluation is performed within 2 weeks of removal from hunger strike list. Detainee's weight and physical condition is monitored closely for 90 days, followed by routine monitoring.

Refusal to Accept Food or Water/Fluids As Medical Treatment

Detainee Number _____ Age _____ Date _____

The above detainee has refused to accept food or water/fluids as medically recommended by the Medical Officer.

The grave risks of not following the medical advice directing him to eat life-sustaining food and to drink water/fluids have been explained to the detainee. He states he understands that as a direct result of his refusal to eat and/or drink, he may experience: hunger, nausea, tiredness, feeling ill, headaches, swelling of his extremities, muscle wasting, abdominal pain, chest pain, irregular heart rhythms, altered level of consciousness, organ failure and coma. He states he understands that his refusal to eat life-sustaining food or drink water/fluids and to follow medical advice may cause irreparable harm to himself or lead to his death. He states he understands that this is not a complete list of the risks involved with the refusal to follow medical advice.

He states he understands the alternatives available to him including oral food and fluid, oral rehydration solutions, oral nutritional supplements, and intravenous fluid hydration.

He states he fully understands the risks to his health if he does not accept food and water as directed above.

Translator/ Witness Signature_____

Medical Provider Signature _____

Hunger Striker Medical Evaluation Sheet

Detainee Number: _____ Date of Evaluation: _____

Date of Onset: _____ Drinking Fluids: Yes No

Number of Meals Missed: _____

HPI:

MEDS: _____

ALLERGIES: NKDA or _____

PMH:

Reason for Hunger Strike? _____

Physical Assessment:

In processing Wt: _____ lbs Pre Hunger Strike Wt: _____ lbs/date:_____

Current Wt: _____lbs ____ % IBW BMI: _____ %Wt Loss: _____

Heart Rate: _____BP: _____/_____RR: _____ T: _____ LOC: Yes No

Other Pertinent Physical Exam and Laboratory Findings:

Assessment: Hunger Striker

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. See *Refusal to Accept Food or Water/Fluids As Medical Treatment*, Enclosure (2).
2. Continue follow-up as per ***Medical Management of Detainees on Hunger Strike*** **SOP No. 001.**
3. Other:

Medical Provider: _____

Hunger Striker Medical Flow Sheet							Detainee ISN #_____
Date	Heart Rate	Blood Pressure	Drinking? mL	Eating? Y/N	Document caloric intake Enteral feed and PO calories	Weight	Comments (ambulatory, coherent, alert, oriented, verbal, etc)

NSN 7540-00-634-4176	AUTHORIZED FOR LOCAL REPRODUCTION
MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
Date/Time	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) JTF–JMG, Medical Department, Guantanamo Bay, Cuba
	Approval Authority for Initiation of Involuntary Enteral Feeding
	Detainee ISN _____ has been on a hunger strike and is refusing to consume life sustaining nutrition and hydration. He meets the following clinical criteria for involuntary enteral feeding.
	____ There is evidence of deleterious health effects reflective of end organ involvement or damage to include but not limited to seizures, syncope or pre-syncope, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are hampered.
	____ There is a pre-existing co-morbidity that might readily predispose to end organ damage (e.g. hypertension, coronary artery disease or any significant heart condition, renal insufficiency or failure, endocrinopathy, etc.).
	____ There is a prolonged period of hunger strike (more than 21 days).
	____ The detainee is at a weight that is less than 85% of the calculated Ideal Body Weight (IBW).
	____ The detainee has experienced significant weight loss (greater than 15%) from previously recorded or in-processing weight.
	Involuntary feeding is required to prevent risk of death or serious harm to health.
	Written approval to initiate involuntary enteral feeding has been obtained from the Joint Task (Note: e-mail written approval is acceptable).
	Force Commander as required per Standard Operating Procedure 001.
	Medical Officer, GTMO

DETAINEE 'S IDENTIFICATION NUMBER:

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDICAL RECORD
STANDARD FORM 600 (rev. 9/05)

Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike

Once a detainee on hunger strike meets the criteria for enteral feeding, the following protocol may be initiated. After initial IV fluid resuscitation, a medically cleared detainee may have treatment initiated with intermittent enteral feedings per Phase IV vice continuous enteral feedings. In event of a mass hunger strike, isolating hunger striking patients from each other is vital to prevent them from achieving solidarity. Given the inability to isolate patients in the DH because of the physical structure of the building, initial IV fluid resuscitation lasting approximately 24 hours can occur in the DH, followed by transfer back to Camp 5 to begin enteral feeding in an environment of single cell operations. .

Phase I: Admit to the Detention Hospital for Intravenous Fluid Resuscitation

Hospital Day #1:

Vital signs should be checked at admission and every four hours for the first eight hours, at which time the frequency can be decreased to every eight hours (if clinically stable).

If not drawn in the past two days, a complete blood count (CBC), basic metabolic panel, calcium (Ca^{++}), magnesium (Mg^{++}), phosphorous (phos), and creatine kinase (CK) should be obtained. A blood glucose reading (finger stick) should be documented in the Medication Administration Record (MAR).

A 12 lead EKG will be performed upon admit.

The detainee's admission weight should be recorded, with weights being recorded daily, thereafter.

Fluid resuscitation should begin with a 1-2-liter bolus of normal saline. The amount of the IV bolus will be decided after reviewing the detainee's medical history for any co-morbid diseases (This may be deferred if fluids were previously received on the block or in the clinic).

Thiamine 100 mg IV one time (Give prior to giving any Dextrose or D_5. This may have already been administered in the Clinic).

This should be followed by a standard formulation, which consists of one liter of D_5 ½ normal saline with 20 mEq KCL, one vial of (water soluble) MVI, 500 mg of magnesium sulfate, one vial of trace elements, and 1 mg of folic acid. This IV formulation should be run @ 100 ml/hr for 10 hours.

Once the formulation has infused, maintenance fluids in the form of D_5 ½ normal saline with 20 mEq KCL @ 100 ml/hr should be started and continued until at least 48 hours after admission (Hospital Day #3)

PRN medications during Phase I:

1) Glucose, 50 grams (D_{50}, 1 amp) IV if blood sugar < 60 and detainee lethargic or unresponsive.

2) Tylenol 650mg PO Q 6 hrs PRN pain, headache.

3) Mylanta 15-30 ml PO Q 4 hrs PRN indigestion, heartburn.

Phase II: Initiation of Enteral Nutrition

Days #2 and #3.

Place a 10 French or 12 French feeding tube into the patient's *stomach* per standard medical practice. Viscous lidocaine should be offered for the nostril and the throat. The tube should be well lubricated prior to insertion. A linguist shall be present to assist with instructions. Once the feeding tube has been inserted, the placement needs to be confirmed. This confirmation can be achieved either by a standard chest x-ray or by air insufflation followed by a 10 ml test dose of water.

The patient's head of the bed should be elevated at least 30-45 degrees while recumbent.

A blood glucose level (via finger stick) should be documented every 12 hours X 3.

The following labs should be considered on a daily basis for the initial 3-5 days after beginning enteral feeding (when the patient is at the high risk for refeeding syndrome): basic metabolic panel, calcium, magnesium, phosphorus, ALT, total bilirubin, amylase, and albumin
Vital signs can be changed to daily (if patient is clinically stable).

Enteral Nutrition:

1. Place 240 ml of **Pulmocare®** in enteral nutrition (EN) bag. Mix one teaspoon of Morton's salt substitute (2300 mg of potassium, 2000 mg of chloride), one teaspoon (8 packets) of table salt (2300 mg of sodium) and liquid MVI, and infuse via feeding tube at 20 ml/hr.

2. After 12 hrs:
If tolerating EN, mix 240 ml of **Pulmocare®** with 360 ml water. Mix one teaspoon of Morton's salt substitute and one teaspoon of table salt, and infuse via feeding tube at a rate of 50 ml/hr (*720 kcal/day + 480 kcal from IV fluids = 1200 kcal/day*).

3. After 24 hrs (start of Hospital Day #3):
If tolerating EN, mix 600 ml of **Pulmocare®** with 400 ml water. Mix one teaspoon of Morton's salt substitute, one teaspoon of table salt and liquid MVI, and infuse at 60 ml/hr *(1296 kcal/day)*. Discontinue IV fluids and IV if fluid resuscitation is complete.

PRN medications during Phase II:

1) Tylenol 650 mg PO/enteral feeding tube Q 6 hrs PRN pain, headache.

2) Mylanta 15-30 ml PO/enteral feeding tube Q 4 hr PRN indigestion, heartburn.

3) Benadryl 25-50 mg PO/enteral feeding tube Q 6 hrs PRN rhinorrhea, post-nasal drip, sneezing, itchy rash, watery eyes.

4) Saline Nasal Spray 2-3 puffs each nostril Q 4-6 hr PRN post-nasal drip or congestion.

5) Phenergan 12.5- 25 mg PO/enteral feeding tube/PR/IM/IV Q 4-6 hrs PRN nausea.

6) Motrin (Ibuprofen) 600 mg PO/enteral feeding tube TID PRN pain (ONLY if nutrition is being tolerated at 20 cc/hr or more; avoid in any patient with concern for renal insufficiency).
7) Reglan 10 mg PO/enteral feeding tube Q 3 hr X 3 doses if nauseated or bloating after tube insertion.

Phase III: Achieving and Maintaining Goal Enteral Nutrition

Day #4-6:

1. After 48 hrs of EN
   Discontinue **Pulmocare®.**

Mix 750 ml of **Boost Plus®** with 250 ml water. Mix one teaspoon of Morton's salt substitute and one teaspoon of table salt and infuse via feeding tube at 60 ml/hr (*1597 kcal/day*).

2. After 72 hrs of EN:
   Increase above nutritional mixture to 80 ml/hr (*2130 kcal/day*).
3. After 96 hrs of EN:
   Increase above nutritional mixture to 100 ml/hr (*2662 kcal/day*) and discontinue table salt.

Phase IV: Intermittent Enteral Nutrition

If patient is clinically stable, nutritional supplementation can be given via intermittent feedings rather than continuous infusion.

This is usually accomplished using a daily or twice daily schedule, with an appropriate quantity of the daily calories being delivered at each feeding.

To enhance gastric motility, the following medication administration may be useful when using intermittent feeds.

1) Metoclopramide (Reglan) 10 mg via enteral feeding tube (place in feeding bag before nutritional supplement).
2) 30 ml magnesium citrate mixed in 500 ml water via enteral feeding tube.

The *Minimum* recommended requirements to transition a patient to intermittent feeding are as follows:

1) 1500 total kcal/day.
2) Four cans of Ensure Plus® or Boost Plus® (or equivalent nutritional supplement).
   If patient is not receiving at least 1000ml enteral formula per day, liquid Centrum (or equivalent) should be added daily until vitamin and mineral minimums can be achieved.
3) Labs as needed to validate normal electrolyte status.
4) Stable clinical condition.

Phase V: Discharge from Detention Hospital to Feeding Block

Once the detainee clinically demonstrates tolerance of hydration, the attending Medical Officer will determine when the detainee can be discharged from the Detention Hospital and transferred to the feeding block. The attending Medical Officer will perform a physical examination of the detainee and document in the medical record that there are no contraindications for the detainee receiving his enteral nutrition on the feeding block. Prior to leaving the DH, the detainee's feeding tube will be removed. Medical staff shall determine the minimum number of enteral feedings necessary to meet the detainee's required nutritional needs. Medical restraints (e.g. chair restraint system) should be used for the safety of the detainee, medical staff, and guard force as outlined in Enclosure (7).

Phase VI: Management of Enterally Fed Detainees Who Terminate Their Hunger Strike

When a hunger striking detainee voluntarily resumes eating or when the detainee has attained 100% of calculated IBW for at least fourteen (14) consecutive days and the attending physician deems it to be medically appropriate, enteral feeding shall cease and oral self-feeding by the detainee shall resume. The Detention Hospital medical staff will medically manage these individuals to avoid complications associated with the resumption of oral nutrition. This medical management will consist of three phases as outlined in Enclosure (10). The first phase will consist of slowly advancing the diet. The second phase will involve the transfer of the detainee to a Transition Block for further monitoring.

And the third phase will consist of the return of the detainee to the mainstream detention camp environment. Enteral feeding shall resume at any point if it becomes medically necessary, in accordance with the SOP.

Warning: This Protocol is intended for guidance only. Changes in clinical course may necessitate variation from this protocol.

Chair Restraint System Clinical Protocol for the Intermittent Enteral Feeding of Detainees on Hunger Strike

At the discretion of the attending Medical Officer, intermittent enteral feedings may be initiated in the DH or designated feeding blocks. Detainees are evaluated daily by medical staff. Intermittent enteral feedings are usually done two times a day. Medical restraints (e.g. chair restraint system) should be used for the safety of the detainee, medical staff, and guard force. The following describes the chair restraint system and feeding procedures used for intermittent enteral feeding on the feeding blocks.

1. Medical provider reviews missed meals logged from guards and medical staff to verify the detainee is still refusing regularly offered (breakfast, lunch, and dinner) meals.
2. Medical staff advises the detainee that hunger striking is detrimental to his health. He is offered a meal and given the chance to eat. If the detainee refuses to voluntarily eat a meal, the enteral feeds are initiated.
3. Medical provider signs medical restraint order to enterally feed the detainee the prescribed diet.
4. Guard force offers detainee restroom privileges (and encourages use of the restroom) before shackles are placed on detainee.
5. Guard force shackles detainee and a mask is placed over the detainee's mouth to prevent spitting and biting.
6. Detainee is escorted to the scale for daily weight. Verify whether detainee has attained 100% of calculated IBW for 14 days or more.
7. Detainee is escorted to the chair restraint system and is appropriately restrained by the guard force.
8. When the guard force advises it is safe, medical personnel initiate the medical restraint monitoring procedures as per SOP 081, obtain vital signs, and document pulses and restraint placement. Using the restraint observation sheet, medical personnel will document circulation checks and detainee condition every 15 minutes.
9. A feeding tube is placed in the stomach as follows:
   a. Topical anesthesia (e.g. viscous lidocaine) will be applied to the appropriate nostril (unless detainee refuses) and the feeding tube OR
   b. Sterile Surgical lubricant (may be substituted with viscous lidocaine or olive oil, if desired by the detainee) is applied to the feeding tube.
   c. The feeding tube is passed via the nasal passage into the stomach. Placement of the feeding tube in the stomach is confirmed using air insufflation with auscultation and a 10 mL test dose of water.
   d. The tube is secured to the nose with tape. The enteral nutrition and water that has been ordered is started and flow rate is adjusted according to detainee's condition and tolerance.
   e. Typically, the feeding can be completed comfortably over 20 to 30 minutes.
   f. After the feeding is completed, the medical staff removes the feeding tube.
10. Upon completion of the nutrient infusion and removal of the feeding tube, the detainee is removed from the restraint chair and placed in a "dry cell". The guard force will observe the detainee for 45-60 minutes for any indications of vomiting or attempts to induce vomiting.
11. If the detainee vomits or attempts to induce vomiting in the "dry cell" his participation in the dry cell protocol will be revoked and he will remain in the restraint chair for the entire observation time period during subsequent feedings.
12. Steps 10 and 11 are contingent upon adequate facility and staffing resources for the detainee census. The detainee will remain in the restraint chair for the feeding and observation periods if either resource is inadequate.
13. The total time the detainee is in the chair restraint system (to include the feeding process and the post-feeding observation) should not exceed 2 hours.

14. The "dry cell" may be the detainee's original cell with the water source turned off temporarily for the observation period.
15. Documentation to include a feeding tube insertion note, restraint observation forms, and nursing notes are completed per JDG restraint protocols SOP 081.
16. Detainees who are chronic enteral feeders and are living in communal blocks may receive enteral feedings under alternative settings. Chronic enteral feeders are notified by the corpstaff that "It is time to feed." If the detainee declines, then no enteral feeding will take place during that session. If the detainee accepts, then the detainee is escorted to the medical clinic or media room as appropriate. The enteral feed will take place with the detainee in single point leg restraint.

MEDICAL EQUATIONS, CALCULATIONS AND DEFINITIONS

Determination of Energy Requirements:

•TOTAL CALORIE PER KILOGRAM METHOD

Classification	Kcal/kg
Morbid obesity	20
Starvation, Ventilated, Intensive Care Unit	25
Ambulatory Maintenance	25-35
Malnutrition/ Moderate Stress	30-35
Severe Injuries/ Stress	35-45

•HARRIS – BENEDICT EQUATION:

Men (kcal/day) = [66.47 + (13.75 x weight (kg)) + (5 x height (cm)) – (6.76 x age)] x activity factor x stress factor

Women (kcal/day) = [655.1 + (9.56 x weight (kg)) + (1.85 x height (cm)) – (4.68 x age)] x activity factor x stress factor

Activity Description	Factor	Stress Description	Factor
Chair or bed bound	1.2 x BEE	Elective surgery	1 – 1.1 x BEE
Seated work with little movement	1.4 – 1.5 x BEE	Multiple trauma	1.4 x BEE
Seated work with little strenuous leisure activity	1.6 – 1.7 x BEE	Severe infection	1.2 – 1.6 x BEE
Standing work	1.8 – 1.9 x BEE	Peritonitis	1.05 – 1.25 x BEE
Strenuous work or highly active leisure activity	2 – 2.4 x BEE	Multiple/long bone fractures	1.1 – 1.3 x BEE
30 – 60 minutes strenuous leisure activity 4 – 5 times/week	2.3 – 2.7 x BEE	Infection with trauma	1.3 – 1.55 x BEE
		Sepsis	1.2 – 1.4 x BEE
		Closed head injury	1.3 x BEE
		Cancer	1.1 – 1.45 x BEE
		Burns	1.5 – 2.1 x BEE
		Fever	1.2 x BEE (per 1°C >37°C)

Determination of Protein Requirements:

Condition	Grams/kg/day
Renal Failure/Dysfunction	0.6 – 0.8 (40 gram min)
Dialysis Patients (moderate stress)	1 – 1.2
Dialysis Patients (high stress) Sepsis Liver Failure/Cirrhosis Re-feeding Syndrome	1.2 – 1.5
Multiple trauma	1.3 – 1.7
Catabolism	1.2 – 2
Post-op	1 – 1.5

Determination of Fluid Requirements:

	Free Water Requirement
1st 10 kg	100 mL/kg
2nd 10 kg	50 mL/kg
Each kg >20 kg	20 mL/kg (≤50 years)
	15 mL/kg (>50 years)
Method 2 – Age	
Young Athletic Adult	40 mL/kg
Most Adults	35 mL/kg
Elderly Adults	30 mL/kg
Method 3 – Energy Expenditure	
1 mL/kcal energy expenditure	

Definitions:

Usual Body Weight (UBW) = The greater of the following:

i. The weight of the detainee at in-processing physical exam.
ii. The weight of the detainee before the hunger strike.

Ideal Body Weight (IBW) = [(Height in inches – 60) x 2.3 + 50] x 2.2

% Ideal Body Weight (% IBW) = [Current Weight (pounds) / Ideal Body Weight (pounds)] x 100

% Weight Loss (% WL) = [Usual Body Weight (pounds) – Current Weight (pounds) / Usual Body Weight (pounds)] x 100

Body Mass Index (BMI) = [Current Weight (pounds) x 703 / Height^2 (inches^2)]

Sources:

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MANAGEMENT OF COMMON ELECTROLYTE DEFICIENCIES

Hypokalemia – Replace potassium with KCL elixir/tablets, 10 milliequivalents for every 0.1 mEq/L below the normal value of 4.0 in the detainee's serum. For example, if a detainee has a serum potassium of 3.4 mEq/L, 60 milliequivalents of KCL elixir/tablets should be ordered.

Hypomagnesemia – Replace with magnesium oxide. Crush four 400 mg tablets (approximately 960 mg of bioavailable magnesium) and mix in water before adding to enteral solution. Continue daily until normal serum Mg^{++} level is confirmed by lab draw. Oral magnesium may cause diarrhea. Alternatively for severe hypomagnesemia, 1-2 grams of magnesium sulfate may be infused intravenously over 30 minutes.

Hypophosphatemia – Replace with 4 packets of Neutra-phos daily (total of 1000 mg of phosphorus, 1112 mg of potassium, and 656 mg of sodium daily) until normal serum phosphorus level is confirmed by lab draw. Oral Neutra-phos may cause diarrhea. Alternatively, for severe hypophosphatemia, 15 mmol of sodium phosphate mixed in 250 ml of ½ NS may be given over 4-6 hours. Usually, this is repeated for a total of 4-8 runs.

Medical Management of Enterally Fed Detainees Who Terminate Their Hunger Strike

When a hunger striking detainee voluntarily resumes eating or when the detainee has attained 100% of calculated IBW for at least fourteen (14) consecutive days and the attending physician deems it to be medically appropriate, oral feeding shall resume. The Detention Hospital medical staff will medically manage these individuals to avoid complications associated with the resumption of oral nutrition in long-term hunger striking. This medical management will consist of three phases. The first phase will consist of slowly advancing the diet. The second phase will involve the transfer of the detainee to a Transition Block for further monitoring. And the third phase will consist of the return of the detainee to the mainstream detention camp environment.

1. RETURN TO ORAL NUTRITION.

   a. When a hunger striking detainee chooses to eat or when the detainee has attained 100% of calculated IBW for at least fourteen (14) consecutive days and the attending physician deems it to be medically appropriate, he will first be offered a bland diet which is often supplemented with yogurt and liquid nutritional supplements such as Ensure®, Boost®, and Jevity®.
   b. During this phase of graduated oral intake, the medical staff will monitor the detainee for evidence of refeeding syndrome that is often characterized by decreased serum phosphorus, magnesium, and potassium levels, as well as peripheral edema.
   c. After the detainee demonstrates a consistent behavior pattern of eating (approximately nine consecutive meals), the Guard Force will consider him for transfer from the Detention Hospital to a transitional block. Prior to transfer, the medical staff will perform a complete medical evaluation to include vital signs, weight, physical exam, and serum blood chemistries to include a basic metabolic panel, complete blood count, liver function tests, and serum magnesium, phosphorus, and calcium.
   d. A representative of the Behavioral Health Services will evaluate the detainee prior to transfer from the Detention Hospital.
   e. Enteral feeding shall resume at any point if it becomes medically necessary, in accordance with the SOP.

2. TRANSFER OF DETAINEE TO A TRANSITION BLOCK

   a. The detainee will be removed from the Hunger Strike list when he is transferred to the Transition Block. The Transition Block will serve as place for the former hunger-striking detainee to begin to be re-assimilated back into the detention camp environment. He will be closely monitored for compliance with consumption of all of his meals.
   b. The Hospital Corpsmen assigned to the Transition Block will visit the detainees daily to pass medications, assist in obtaining weights, conduct sick call, and to dispense supplemental liquid nutrition. The detainee can have up to two cans of vanilla flavored Ensure® two to three times a day. The Guard Force will facilitate the dispensing of the Ensure® using Styrofoam cups.
   c. A Medical Officer will visit the detainee daily or as clinically indicated to monitor the former hunger striker.
   d. The assigned Guard Force at the Transition Block will take accurate daily weights on each former hunger striker and put this information in the Detainee Information Management System (DIMS).
   e. After a sufficient period of observation (9 additional, consecutive meals) that satisfies both the Joint Detention Group and the Detention Hospital Medical Staff that the former hunger

striker is tolerating a regular diet, the detainee will be transferred back to a mainstream detention camp block.

f. Prior to transfer off the Transition Block, a Medical Officer will perform a complete medical evaluation to include vital signs, weight, physical exam, and serum blood chemistries to include basic metabolic panel, complete blood count, liver function tests, and serum magnesium, phosphorus, and calcium.

g. Prior to transfer, a member of the medical staff will counsel the detainee that a return to hunger striking would be extremely detrimental to his health.

3. RETURN TO THE MAINSTREAM DETENTION CAMP ENVIRONMENT

a. A medical provider will perform a complete medical evaluation on all prior enterally fed detainees within approximately 2 weeks after resumption of a regular diet and re-integration into the general camp population. This medical evaluation will include vital signs, a weight, a physical examination, and blood work to include a basic metabolic panel, liver function tests, a complete blood count, and serum magnesium, phosphorus, and calcium. The results of these evaluations will be recorded in the detainee's outpatient medical record. The evaluation should also include an assessment of the detainee's need for physical therapy services. Prior enterally fed detainees found to have medical issues or to exhibit signs or symptoms associated with refeeding syndrome will have subsequent follow up visits in the outpatient clinic, as medically indicated.

b. A member of the medical staff will counsel the detainee that a return to hunger striking would be extremely detrimental to his health.

DETENTION HOSPITAL GUANTANAMO BAY, CUBA Title: PROCEDURES FOR SETTING UP AN ENTERNAL FEED (EF)	SOP NO: TACMEMO #01 Supplemental to JTF-JMG SOP #001 Effective Date: 05 Mar 13
SCOPE: JOINT TASK FORCE-DETENTION HOSPITAL	

I. BACKGROUND

Many detainees attempt to manipulate enteral feeding (EF) times by admonishing the staff administering them that the drip rates are too fast, or directing the order of ingredients, i.e.: adding milk after the Ensure ™ has been given. Collectively, this has had the effect of prolonging the total time spent in the feeding chair and has given detainees a measure of control over an involuntary process. Standardization of the process for setting up enteral feeding ensures that JMG staff act in a safe, humane, and consistent manner, and will reinforce the equal treatment of detainees according to SOP.

KEY CONCEPTS:

- Personal safety of JMG staff is paramount.
- Enteral feeding is being given as a lifesaving procedure.
- Detainees are not to direct the contents, or order of ingredients of EF.
- Detainees may not direct the speed of the EF, unless it is causing abdominal pain.
- Detainees may not choose their location while being enterally fed.
- There are medications which can be given (anti-emetics, pro-kinetics, phenergan, reglan, metamucil), which can enhance comfort during EF. Detainees should be always be offered these medications if they experience discomfort.

II. POLICY

A. Upon receipt of JTF's approval for enteral feeding, feeding times and locations shall be under the direction of the JDG Commander, meeting daily caloric requirements.

B. Enteral feeding solutions will be prepared in accordance with the JMG physician's orders and out of the line of sight of detainees. The entire EF solution as ordered by the physician will be added before connecting the bag to the EF tube.

C. An IV pole will be utilized. Place the IV pole behind the detainee and out of his field of vision, as room allows.

D. A new enteral feeding tube (EFT) will be used for each EF unless a detainee requests to reuse a EF tube. Upon detainee request, reuse of EF tube is authorized IAW with SOP #092. The EF reservoir bag must be clearly marked with the detainee's ISN number, and is to be discarded at the end of each day.

III. PROCEDURE

A. The detainee will be placed in the feeding chair per SOP NO: JTF-JMG #001, and oriented so that his back is to the cell door. The EF solution will be hung behind detainees as far as possible

without impeding RN access to the EF bag. If a detainee is to be fed while laying on a gurney, a written order from a physician is required. Any such order must be included in the enteral feeding order. The detainee must be restrained by the guard staff according to JDG guidelines and the head of the bed must be elevated to at least 45 degrees.

B. The detainee should be offered a chance to use the toilet before being placed in a feeding chair. If he must use the toilet during enteral feeding, and line-of-sight cannot be maintained, the EFT must be removed and re-started to finish the EF.

C. The goal is to complete the EF within times outlined in SOP NO: JTF-JMG #001. If the detainee complains that EF is being instilled too fast, first ensure that it is being administered per established SOP. The RN should ask if the detainee is nauseous, or is having pain.

1. If detainee is experiencing nausea, the RN should offer the detainee any PRN nausea or pro-kinetic medications available as ordered.

2. If the detainee complains of pain, assess the detainee to ensure that the NG tube has been properly placed and functioning normally. Inform the detainee that the EF is being given under safe, acceptable, and humane guidelines, and is being given under a doctor's orders. Palpate abdomen for overly distended stomach. Slow until complaint of pain is resolved. The EF will not be discontinued if there is any EF solution remaining in the bag unless the 2 hour time limit has been reached. Do not allow the detainee to manipulate the flow of the EF; secure the EFT so that the detainee cannot reach it with his hands.

3. If detainee attempts to change the order or ingredients of the EF, inform him that the EF is being given under a doctor's order, for medical necessity, and will not be changed by the RN.

4. The following standard responses will be used to respond to detainee questions or protests of ingredients to EF:

(a). If the detainee requests that certain items be added to the EF, or if the detainee asks why he cannot be given certain ingredients in the EF the nurse will reply:

"This is the formula that the doctor has ordered for your nutritional requirements. I am not permitted to make any changes to the order".

(b). If the detainee demands to speak to the doctor, the nurse will reply:

"I will write a note in your chart for the doctor".

(c). If the detainee attempts to slow the EF process by stating that the EF is infusing too fast, the nurse will reply:

"The doctor has ordered some medication which may help with nausea; would you like me to administer it?"

(d). If the detainee attempts to direct the nurse to place him in a particular location during EF, the nurse will reply:

"This is a decision for the guards to make."

D. Ensure personal safety during EF, refer to JDG SOP #33 for proper management of detainees while restrained for enteral feeding. If the RN or HM feels as if they are in any danger of BFE or personal harm, withdraw from the situation and speak with the guards to inform them of their concerns.

E. It is appropriate for the nurse to direct guards to wash the hands of detainees who present for EF with feces on their hands in accordance with the JDG SOP #85.

F. If any detainee threatens the nurse with physical assault or exposure to body fluids, each occurrence must be reported to the guard staff immediately.

G. For detainees admitted to the BHU and receiving enteral nutrition: If deemed appropriate and necessary, the BHU medical director may direct nursing staff to use weighted or non-weighted EF tube based upon individual assessments of the detainee's potential to bite the EFT. The decision to use a weighted versus non-weighted EFT will be made after consultation with the SMO and EF physician, and will be written as an order in the detainee's medical chart. Nursing staff may not change the size or type of tube without a written order.

H. The EF reservoir bag will be flushed with at least 300 mL of tap water or until clean. It may be re-used for the same detainee on the same day, **but is to be disposed of at the end of each day**.

I. The number of calories which are received will be documented both in the nursing notes and on the Hunger Striker Medical Flow Sheet.

IV. APPLICABILITY

The tactical procedure delineated above is applicable to all the enteral feedings performed by JMG personnel.

DETENTION HOSPITAL GUANTANAMO BAY, CUBA Title: STRATEGY FOR DETAINEE BITING ENTERAL FEED TUBE	SOP NO: TACMEMO #02 Supplemental to JTF-JMG SOP #001 Effective Date: 05Mar 13
SCOPE: JOINT TASK FORCE-DETENTION HOSPITAL	

I. BACKGROUND

On occasion, a detainee undergoing enteral feeding (EF) will attempt to bite the tube in an attempt to swallow the feeding tube, necessitating serial exams and possible EGD removal of the tube. Identification of these detainees and management of the EF tube will assist the RN in reducing the incidence of this event. The detainee may attempt to bite the portion of the tube outside the nose by turning his head and snaring the tube with his mouth, or may attempt to regurgitate the tube partially into the oral cavity and attempt to sever the tube covertly without opening his mouth. This is especially difficult to assess in the non-compliant detainee when it is necessary to affix a "spit mask" over his mouth. The JMG staff may utilize the following strategy to manage the behavior

KEY CONCEPTS:

- Personal safety of JMG staff is paramount.
- Detainee may try to bite the RN during the EF tube insertion.
- Guard staff should be appropriately utilized for monitoring behavior and securing a detainee for the safety of JMG staff.
- Special care is to be taken whenever procedures are initiated near a detainee's mouth.

II. POLICY

Biting tube OUTSIDE the mouth:

A. If a detainee is actively attempting to turn his head to bite the tube between the nose to the EF bag, the RN will affix the tube with tape to the midline of the detainee's nose and extend it upwards, affixing it with tape to the detainee's forehead.

B. If a detainee is actively attempting to bite the nurse, the nurse will immediately withdraw until the detainee is appropriately restrained.

C. If the behavior persists, and there is legitimate concern that the detainee may still be able to bite the tube. The RN shall direct a member of the guard staff to continually monitor the detainee during the EF session.

D. To reduce head and jaw motion during insertion of the EF tube if required:

1. While the detainee is seated and appropriately restrained in the feeding chair, one guard will position themselves behind the detainee and hold the detainee's head in the midline position.

2. When the Nurse is satisfied that the detainee is secured and a safe environment exists, they shall insert the EF tube iaw SOP NO: JTF-JMG #001 and secure it as described in (A).
3. The guard may then release their hold on the detainee's head

E. If a particular detainee displays repeated attempts to bite the tube, a weighted 10f tube shall be used for all subsequent EF.

F. If the detainee is able to gain the tube between his teeth, the nurse will:
1. Simultaneously turn off feed and, immediately stabilize the distal end of the tube and pull the tube from the detainee's nose.
2. Maintain traction on the proximal portion of the tube until the detainee releases the tube from between his teeth. This may take considerable time.

Biting the tube INSIDE the mouth:

A. If a detainee is noted to be attempting to chew the tube, the RN should ask the detainee to open his mouth for a visual confirmation that the tube is intact. If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF.

B. The RN will direct guard staff to maintain continuous visualization of the detainee's jaw to assess for chewing.

C. If detainee is able to get the EF tube between his teeth, the RN shall:
1. Immediately stop the enteral feeding while simultaneously maintaining gentle traction on the EF tube.
2. Direct the guard staff to stabilize detainee's head in the midline position.
3. Hold traction on the tube for as long as necessary for the detainee to relax his jaw; then continue safe removal of the tube. This may take considerable time.

D. If any particular detainees continually attempt to bite the tube. The RN will direct guard staff to maintain 1:1 visual monitoring of detainee during EF sessions.

III APPLICABILITY

The tactical procedure outlined above is applicable to all JMG personnel who are involved in the enteral feeding of detainees.

APPROVED BY:

[redacted] 4 APR 2013
Signature/ Printed Name Date
Commander, Joint Medical Group

RECOMMENDED BY:

_____/_____ _____
Signature/ Printed Name Required: ☒Yes ☐No Date
Deputy Commander, Joint Medical Group

_____/_____ _____
Signature/ Printed Name Required: ☐Yes ☐No Date
Senior Medical Officer

_____/_____ _____
Signature/ Printed Name Required: ☐Yes ☐No Date
Senior Nurse Executive

_____/_____ _____
Signature/ Printed Name Required: ☐Yes ☐No Date
Director For Administration

_____/_____ _____
Signature/ Printed Name Required: ☐Yes ☐No Date
Medical Planner

_____/_____ _____
Signature/ Printed Name Required: ☐Yes ☐No Date
Senior Enlisted Leader

_____/_____ _____
Signature/ Printed Name Required: ☐Yes ☐No Date
Director, Behavioral Health Services

REVIEW LOG: Directorate Reviewer:
Sig:_____ Date:_____
Sig:_____ Date:_____
Sig:_____ Date:_____

SOP SUPERCEDED/ CANCELLED THIS DATE:

_____/_____ _____
Signature/ Printed Name Date
Commander, Joint Medical Group